

# Health Care For Residents of Public Housing Quarterly Information Bulletin



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## Two PHPC Health Centers Receive Special Populations Service Recognition Award at HRSA All Grantee Meeting

Two PHPC grantees, Grace Hill Neighborhood Health Centers (GHNHC), Inc, St. Louis, MO, and Kokua Kalihi Comprehensive Family Services, Honolulu, HI, received Special Populations Service Recognition awards at the June 2008 Primary Health Care All Grantee Meeting held in National Harbor, Maryland.

The award was given to recognize migrant health centers, homeless clinics and public housing health centers that support the mission of access to comprehensive, culturally competent, quality primary health care in special need areas. The award criteria was based on health centers/programs that demonstrated the ability to make connections with the communities it serves through quality service delivery, cultural diversity, and leadership in these special need areas and uses innovative approaches to address primary health care needs. Grantees were nominated by their respective Project Officer.

Grace Hill received award for their work providing health services to the homeless. Grace Hill currently has contracts regarding homeless services with the county health department and about 30 shelters in their service area. To further expand on their impact, Grace Hill

contracted with three other Federally Qualified Health Centers (FQHC) in St. Louis. These other FQHCs provide health services to homeless patients through contracts with Grace Hill. Additionally, Grace Hill has established a partnership with an area hospital discharging and emergency room department, so that GHNHC employees will be notified when homeless patients needing follow-up care are discharged. Lastly, GHNHC has a mobile dental van that provides on-site dental services at homeless shelters.

Kokua Kalihi Valley (KKV) Comprehensive Family Services was recognized for their work with Kalihi Valley's low-income, predominantly Asian American and Pacific Islander (AAPI) immigrant and public housing communities. KKV utilizes group visits that are culturally appropriate in working with the AAPI population. This population is more comfortable in groups that are linguistically familiar and population specific. In conjunction with the group visits, KKV runs a weekly weight loss program that includes a curriculum of exercise, education and cooking demonstrations done in the patients' native languages. ■

## 2008 Health Care for Residents of Public Housing National Conference Chicago, IL

Nearly 200 participants attended this year's conference to discuss ways to address the health needs of residents of public housing. Participants included federal, state and local governmental officials, housing authority administrators, PHPC grantees, residents of public housing, primary care associations, health educators, social workers, clinical staff, lay/health outreach workers, and researchers.

On the first two days at the Health Center CEO pre-workshop meetings, the CEOs had an opportunity to meet

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and share mutual concerns with Henry Lopez, Jr., Director of Minority and Special Populations, HRSA. The concerns included changes from centralized residents to decentralized, more geographically dispersed HOPE VI housing, funding for health center facilities, and recruitment and retention of health center staff.

A second pre-workshop meeting was entitled *How to Build and Initiate Partnerships*. The roundtable meeting discussed ways the Cooperative Agreement can provide technical assistance to prospective PHPC grantees as well as programmatic implementation.

The conference opened with a film presentation *Making a Difference*, by Primary Health Service Center in Monroe, LA. The presentation highlighted the work of the health center in serving underserved populations in Monroe in the areas of mental health and domestic violence.

The opening day keynote speaker

was Mrs. Sandra Moore, Esq. President of Urban Strategies. Mrs. Moore's presentation was entitled *Making Communities Work: Getting Healthy*. Ms. Moore encouraged



participants to provide residents with strategies to live healthier, more productive lives in safe, stable, self-sustaining urban communities by working closely with community leaders and dedicated stakeholders.

Day two of the conference opened with a welcome address by Lewis Jordan, CEO of the Chicago Housing Authority. Mr. Jordan expressed his

gratitude for the work of health centers in improving the lives of public housing residents.

The second day's plenary was entitled *Chicago's Plan for Transformation of Public Housing and Future Planning for the Delivery of Health Care Services to Public Housing Residents*. This session was moderated by Henry Taylor, Executive Director of Mile Square Community Health Center and Chair of the Illinois Primary Care Association (PCA) and the presenters were Joseph M. Harrington, Assistant Commissioner Chicago Department of Public Health; Andrew Teitelman, Vice President, Resident Services, Chicago Housing Authority; and Rhonda Mundhenk, Development Director, Mile Square Health Center.

The last day was a half day of breakout sessions. The conference ended with a *2009 Planning Committee Meeting*, which was open to all interested participants. ■

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## 2008 National Conference: Highly Rated Workshops

At the 2008 *Health Care for Residents of Public Housing Conference*, there were 30 training/technical assistance workshops that covered a range of topics including primary and dental care, behavioral health and substance abuse, operations and administration, community outreach, research and HUD funding opportunities. Each workshop was evaluated by conference participants. The following presentations received the highest ratings in the *Usefulness of the Content* category.

### ***Working with Low-Income Communities in Chicago to Reduce Hunger and Improve Nutrition*** ***by Erlinda Bingham and Dale Cain***

This workshop focused on how Chicago's Near North Health Service Corporation and their partner, Share Our Strength collaborated to leverage local and national resources to teach families how to prepare healthy low-cost meals to reach low-income families. This program has successfully cultivated partnerships with culinary schools, community and faith-based organizations. The workshop engaged the audience with an interactive nutritional learning activity and a simulated cooking demonstration which provided the audience with an opportunity to sample various seasonings used to cook healthy foods.

### ***Challenges in Site Expansion*** ***by Wayne Rowe and Donna Torrisi***

As Health Center Executives, the presenters were able to communicate first hand experiences of the expansions at their health centers. Some of the main reasons for their site expansions included end of lease, limited space, and the desire to add services. Things to consider before expanding a health center are the proximity to public housing, access to public transportation, location relative to other federally qualified health centers, and purchasing versus renting. Key challenges that health centers may face are the cost of rent, renovation cost and raising funds for renovation and outfitting. Donna Torrisi encouraged participants to look at all options for raising funds including state Challenge Grants, the Federal Appropriations Grant, State Redevelopment Assistance Capital Program, foundations, and private fundraising. In addition, when fundraising for a site expansion, health center executives should talk to anyone and everyone.

### ***Creating a Dental Home for Residents of Public Housing*** ***by Frank Torrisi***

As the Network Dental Director for the Eleventh Street Family Services, Frank Torrisi was able to provide an

extensive account of the process of establishing and sustaining a dental service site for residents of public housing communities. The steps necessary to apply for state, federal and private funding support, the requirements of setting up a new dental service site, ideas for developing supportive partnerships with medical schools and other groups, and long term strategies for survival were explained in detail. The presenter gave an overview of the concept of a "Dental Home" and the challenges involved in providing comprehensive dental services at a single site for residents of public housing.

### ***Health Literacy: Understanding the Scope of the Problem and Identifying Opportunities for Collaboration Between Federally-Funded Public Housing and Migrant Programs*** ***by Alicia Gonzales***

The ability to read and understand health information and apply it effectively is a growing public health concern. Health Literacy is important because it affects people's ability to navigate the healthcare system, share personal and health information with providers, engage in self-care and chronic disease management, and adopt health-promoting behaviors. These outcomes impact healthcare cost, health outcomes, and quality of care. Participants had an opportunity to explore specific patient behaviors and responses that indicate limited literacy: incomplete registration forms, missed appointments, not adhering to medication regimen, lack of follow through with diagnostic testing, and not taking medications. Lastly, the presenter explained how migrant health and public housing programs can work together to address the health literacy issues with their targeted communities.

### ***Exposing Domestic Violence, To End Domestic Violence: Putting the Pieces Together*** ***by Catherine Tonore, Rhonda Beard, Akwete Noble and GinnyLea Tonore***

The presenters described domestic violence as a pattern  
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of coercive and controlling behaviors used to gain power and control over another. Abuse can be verbal, emotional, psychological, financial, sexual and/or physical. Domestic violence is not an isolated, individual event, but a series of controlling and manipulative behaviors used to control the victim.

Domestic violence usually escalates over time and can result in serious injury or death. Suggested responsibilities for health care providers were identified as: identifying and acknowledging abuse, providing sensitive support, documenting abuse and providing referral and resource materials. The goal for providers is to become comfortable with asking about domestic violence and making it a part of the clinical routine. Indicators requiring further assessment were identified as somatic complaints without diagnosis, post-traumatic stress symptoms, gastrointestinal pain, unexplainable neurological changes, depression, multiple or erratic visits with a series of vague complaints.

***Innovative Strategies to Address the Health and Social Disparities Using the Care Model: Addressing Men's Health and Healthcare by Frederica Williams***

Some of the attitudinal barriers to men's participation in healthcare were identified as gender role stoicism, work role stoicism, distrust of the health care system, fatalism: "you've got to die of something," maladaptive self-reliance: "a man takes care of his own problems." The health care system barriers included work schedule conflicts and health care availability hours, lack of male-targeted health programs and economic barriers (health insurance).

Elements of Whittier's Men's Health Program includes a Men's Health department staffed by four male staff, an annual all day Men's Health Summit, which attracts 300-400 men, a 12-week peer leadership program for men to serve as Health Ambassadors, and a Men's Health curriculum to educate men about preventable diseases.

The program is also a referral source for social services not provided at the center and includes job placement, skills development, housing, education, etc. Whittier's staff work with community organizations, public housing residents, and faith-based organizations, correctional facilities, hospitals and providers to increase the recruitment and retention of Black and Latino males.

***Using HUD Funded ROSS Grants to Improve Health and Self-Sufficiency by Anice Schervish***

This workshop was an in-depth presentation explaining the ROSS Service Coordinator funding application process, which was due August 14th. Service Coordination provides a vital link between the resident, the community and its resources. The Service Coordinator connects frail and disabled residents and families with available community support services. These support services can empower residents to remain living independently and as self-sufficiently as possible in their community. Applicants must be able to demonstrate that they have a high quality program, a 25 percent funding match (cash or in-kind) from a partner, and program capacity/past performance. Public housing authorities, health centers and non-profits who serve residents of public housing and assisted housing are eligible to apply.

*Note: Notice of this HUD funding opportunities was sent in advance through the National Center's list serve.*

***Contracting with an HMO from a Business Perspective by Eric Taylor***

Financial risk was defined as risk to actual income and can be associated with different payment models. The presenter covered HMOs' multiple types of contracts for different service requirements, such as primary care provider, specialty provider, hospital, specialty hospital service, home health provider, pharmacy provider, and nursing home provider. Contracting issues were discussed ranging from credentialing to enrollment, grievance and appeal processes, licensure requirements, enrollment type including open access, point of service plans, quality assurance, reimbursement methodologies, reports and rate filings, utilization management reviews, and disease management requirements. Recently, HMOs have included pay-for-performance in some of its contracts. Mr. Taylor also discussed that success is achieved by three main functions: utilization management, disease management/case management and claims cost management. Success is also achieved by the number of covered lives or enrollee membership.

*For additional information on these and other conference presentations made available to us, please visit the resources section of our website: [www.healthandpublichousing.org](http://www.healthandpublichousing.org). ■*

# A New Web-Accessible Tool Kit for PHPC Clinicians

The Association of Clinicians for the Underserved (ACU) has developed an extensive web-based tool kit designed to help PHPC and other clinicians that serve residents of public housing in implementing the Care Model. The tool kit was developed by Lois Wessel, RN, CFNP of ACU and Kathy Brieger, MA, RD, CDE of Hudson River Health Care, Inc. In addition, the Clinical Quality Workgroup, comprised of representatives from 11 PHPC grantees, reviewed and advised during the development of the document. This resource is broken into the following six sections which guide users through the process.

## 1. Community Resource Documents

This section refers to the utilization of existing community resources for patients and the need for health care organizations to form partnerships with community-based organizations, as well as advocate for service and police improvements for patients. It explains how to encourage patients to participate in effective community programs; form partnerships with community organizations to develop interventions that fill service gaps; and advocate for policies to improve care.

## 2. Health Systems, Organization of Care

This section focuses on systems that promote safe, high-quality care. Providers should work towards comprehensive system change, provide incentives to improve quality of care, and develop systems for coordinating care across organizations. It explains how to visibly support improvement at all levels of the organization; promote effective improvement strategies aimed at comprehensive system change; encourage open and systematic handling and quality problems to improve care; provide incentives based on quality of care, and develop agreements within and across organizations.

## 3. Self-Management Support: Empower and Prepare Patients to Manage their Health

This section promotes activities to empower and prepare patients to manage their health care. It reflects the patient's central role in care and treatment and stresses use of self-management support strategies, including assessment, goal setting, action planning, problem solving, and follow-up. It explains how to emphasize the patient's central role in their health; use effective self-management support strategies; organize internal and community resources to provide ongoing self-management support to patients.

## 4. Delivery System Design: Assure the Delivery of Effective, Efficient Care and Self-Management Support

This section refers to a process of ensuring delivery of effective and efficient clinical care and self-management support. The system should promote definition of roles

among the clinical care team, a structure for communication and service delivery between the team members and clients, and regular follow-up. It explains how to define roles and distribute tasks among team members; use planned interactions to support evidence-based care; provide case management services for complex patients; and ensure regular follow-up by the care team.

## 5. Decision Support: Promote Clinical Care that is Consistent with Scientific Evidence and Patient References

This section shows processes and procedures that promote care that is consistent with scientific evidence and patient preferences. Clinical practice should reflect treatment guidelines. Decision support should use proven methods of provider education and integrate specialist expertise and primary care. It explains how to embed evidence-based guidelines into clinical practice; integrate specialist expertise and primary care; use proven provider education methods; and share evidence-based guidelines and information with patients to encourage their participation

## 6. Clinical Information System: Organize Patient and Population Data to Facilitate Efficient, Effective Care

This section explains why providers should use data to facilitate effective care. Data systems monitor the performance of the care system and provide reminders for both providers and patients. It explains how to provide timely reminders for providers and patients; identify relevant subpopulations for proactive care; facilitate individual patient care planning; share information to coordinate care; and monitor performance of practice team and care system.

*This tool kit was developed by ACU under contract with the National Center for Health Care for Residents of Public Housing, North American Management. To access the tool kit, please visit the resources section of our website at [www.healthandpublichousing.org](http://www.healthandpublichousing.org). ■*

# Expanding the Network: Health Centers Serving Residents of Public Housing

We continue to expand our network of health centers that serve residents of public housing by including the following non-PHPC funded health centers. Some of these health centers attended this year's national conference and others we learned of while working with the Virginia Primary Care Association.

## **Near North Health Services Corporation**

**Chicago, IL**, is the largest provider of community-based primary care in Chicago. Residents of the Near North Side (Cabrini Green), West Town, Humboldt Park, West Garfield Park, Austin, Kenwood/Oakland, Douglas and Grand Boulevard, are provided with healthcare, social services and nutrition education.

## **South Central Houston Community Health Center**

**Houston, TX**, has two locations serving over 13,000 residents yearly. The health centers are located near three public housing communities, Cuney Homes, Scott Terrace and the Wilmington House. South Central and mobile clinic, United Neighborhood is looking forward to working with these communities to improve the health and quality of life of residents.

## **Joseph P. Addabbo Family Health Center**

**Arverne, NY**, provides comprehensive health services to residents of public housing in the communities of Redfern, Edgemere, Hammels, and Queens, New York.

**New Horizons Healthcare, Roanoke, VA** provides primary care, laboratory, pharmacy assistance and behavioral health services to the Roanoke Valley Community. With public housing located nearby, New Horizon's looks to improve the services they provide to this population.

**Blue Ridge Medical Center, Arrington, VA**, is located between two public housing developments and is also interested in how to better serve nearby residents of low income senior housing.

## **ProHealth Rural Health Services, Inc.**

**Franklin, TN**, annually provides primary and behavioral health care to more than 5,000 residents of Williamson, Davidson, Giles and Maury County in Tennessee. Approximately 60 percent of their patients are residents of public housing from two local public housing campuses. ProHealth is currently cultivating a partnership with Franklin and Columbia Housing Authority to provide additional healthcare services and health screenings to public housing residents.

## **Seminole Community Mental Health Center, Inc.**

**(SCMHC) Fern Park, FL**, provides comprehensive mental health and substance abuse services to Seminole County residents. SCMHC has developed into a multi-campus, comprehensive mental health agency with more than 10 programs. Seminole works very closely with Sandford Housing Authority to provide services to residents.

## **Portsmouth Community Health Center, Inc.**

**Portsmouth, VA** provides medical and dental services to over 9,000. They would like to strengthen their connection with the Hope VI staff at their local housing authority to better serve two nearby public housing communities.

## **Oklahoma Community Health Services (OCHS)**

**Oklahoma City, OK**, provides premium medical and dental services to 21,000 patients annually including low-income families, the uninsured and many susceptible and high-risk populations.

## **Stony Creek Community Health Center, Stony Creek, VA**

, currently provides medical services to residents of Stony Creek and the surrounding area. They are developing strategies to serve the residents of a new federally-assisted housing development being planned for the area.

## **Southwest Virginia Community Health Systems**

**Saltville, VA** has six clinic sites in Southwestern Virginia. It is committed to provide access to affordable, quality, comprehensive, and preventative healthcare that is culturally sensitive for all individuals, while maintaining partnerships with the community in order to enhance economic stability and provide local employment opportunities.

## **United Neighborhood Health Services**

**Nashville, TN**, serves residents of public housing of Nashville/Davidson County and Middle Tennessee. Through its six neighborhood clinics, three school clinics and mobile clinic, United Neighborhood has grown to be the "family doctor" for over 20,000 children and adults in Nashville, TN. ■

## Awards and Recognition to Seven PHPC Health Centers

In 1991, the Department of Health and Human Services, Health Services and Resources Administration (HRSA) established the Public Housing Primary Care (PHPC) program and funded the first seven PHPC health center grantees. Today, there are 45 PHPC health centers located across the nation.

This year, the PHPC peers of the first seven PHPC health centers honored and paid tribute to the seven with an awards ceremony. On behalf of the PHPC grantees, Henry Taylor, Executive Director of Mile Square Community Health Center, Chicago, IL, presented special awards to Daisy L. Harris, President, West End Medical Centers, Atlanta, GA and Wilford Payne, Primary Care Health Services, Pittsburgh, PA for their commitment and dedication and many years championing the PHPC program.

Allen E. Patterson, Chief Financial and Operating Officer, Heart of Texas Community Health Center, Waco, TX, one of the newest PHPC grantees, presented plaques to representatives of the first seven PHPC grantees to acknowledge their leadership and dedication over the past 18 years.

Plaques were presented to the following :

CommuniCare Health Care Centers, (formerly known as Ella Austin Health Center), San Antonio Texas;

Donna Torrisi, Executive Director, Family Practice and Counseling Network, Resources for Human Development, Philadelphia, Pennsylvania;

Villie M. Appoo, Executive Vice President, Planning and Development, Grace Hill Neighborhood Health Centers, St. Louis, Missouri;

John Hess, Vice President, Planning and Development, Great Brook Valley Health Center, Worcester, MA;

Len Lavender, Primary Care Health Services, Pittsburgh, Pennsylvania;

Veronica Clarke, Chief Executive Officer, TCA Health, Inc, (formerly known as The Clinic at Altgeld), Chicago, Illinois; and

Daisy L. Harris, President and CEO, West End Medical Centers, Atlanta, Georgia.

The PHPC grantees also recognized the work of HRSA Special Advisor, LaVerne Green with a special appreciation plaque for her dedication and commitment to PHPC program. Under her tenure the program has flourished; expanding both in number of grantees and resource opportunities.

Congratulations to all the individuals and health centers recognized at the conference.